ALASKA STATE MEDICAL BOARD

Department of Community and Economic Development
Division of Occupational Licensing
(333 Willoughby Avenue - Ninth Floor)
Post Office Box 110806, Juneau Alaska 99811-0806
A – K: 907/465-2756 L – Z : 907/465-2541
E-Mail: license@dced.state.ak.us

COURTESY LICENSE APPLICATION
IMPORTANT INFORMATION - PLEASE READ CAREFULLY

PURPOSE OF A COURTESY LICENSE

Alaska law provides for the issuance of a courtesy license to a physician for specific, limited purposes. The board has approved the following purposes for the use of the courtesy license:

1. Physicians who will be working in a supervised hospital fellowship;
2. Physicians who will be working in a specialty clinic where there is no fee or other remuneration paid by the patients for the service;
3. Physicians who will be working in specialty clinics under formal contract to a state office;
4. Sports team physicians who are accompanying their teams to this state for competition;
5. Physicians who will be accompanying their employer/patient to the state;
6. Physicians who will be providing emergency medical care or emergency mental health care, as part of an organized response to a state declared disaster that resulted in injuries or death.

The courtesy license is valid only for the duration of the activity but may not exceed one year in length.

QUALIFICATIONS FOR A COURTESY LICENSE

1. Successful graduation from an accredited medical school if U.S. or Canadian graduate; if any another international medical school graduate, successful graduation from a school listed in the World Health Organization directory of medical schools.
2. Successful completion of post-graduate training
3. Active license in good standing (no disciplinary sanctions or restrictions) in state of residence; cannot be under investigation.
4. Board certification in an American Board of Medical Specialties member board.

CONTENTS OF A COMPLETE APPLICATION

1. Application (8 pages)
2. Fees ($350 total)
3. Statement of Purpose
4. Release of Records
5. Verification of state license from state of residence
6. Current Curriculum Vitae
7. DEA Clearance Report
8. FSMB Board Action Data Bank Clearance Report
9. Certified True Copy of Medical School Diploma
10. Certified True Copies of All Post-Graduate Training Certificates
11. Certified True Copy of Board Certificate (must be an ABMS member board)
12. Fellowship Scope of Practice Statement, if courtesy license is for a fellowship position - not required otherwise.

GENERAL INFORMATION

ADDRESS OF RECORD

Item 8 of the application asks for your preferred address of record. This is the address to which you would like us to send all communications to you including your permit or license. This is also the address that is available to the public. If you choose to use a third party address such as an employment or staffing agency, we are not responsible for mail reaching you directly.

APPLICATION STATUS UPDATES

Our licensing examiner will send you a written status update upon the initial screening of the application.

CERTIFIED TRUE COPIES

To obtain a certified true copy, take the original document to a notary public so he/she may compare the original to the photocopy of the document. **The notary must write "I certify this to be a true copy of the original document." on the photocopy and attest to the fact by signing and notarizing the document.**

COMPLETION OF THE APPLICATION FORMS

Help us do a good job processing your application: type or print legibly all application documents. Please read the instructions and give careful thought before answering the questions in the application - remember - you are certifying that the information is truthful and correct. Make sure all notary seals are properly affixed on the application and all documentation has been properly certified as required. Provide all documents requested in the application; incomplete applications will delay processing.

Each question in the application must be answered. Attach separate sheets of paper, labeled with your name and signed by you, for any question for which you have provided a YES response

Failure to answer all questions completely and accurately, or the omission or falsification of information may be cause for denial of your application or disciplinary action if the board subsequently permits you. WHEN IN DOUBT, DISCLOSE ALL INFORMATION OR CALL OUR OFFICE.

CONFIDENTIALITY

The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

DEA CLEARANCE REPORT

You are required to request a clearance report from the Drug Enforcement Administration for your DEA registration. Use the form provided in this packet and send your request to:

Drug Enforcement Administration
400 Second Avenue West
Seattle, WA 98119-4013

DENIAL OF LICENSE

The denial of an application for licensure may be reported to any person, professional licensing board, federal, state, or local government agency, or other entity making a relevant inquiry or as may be required by law.

FAX DOCUMENTS

Fax copies of documents are **NOT** accepted for documentation or verification in our licensing process.

FEES

Fees for a courtesy license are:	$150	Nonrefundable Application Fee
	$200	Permanent License Fee
	$350	**Total Due Upon Application**

FOREIGN LANGUAGE DOCUMENTS

All foreign language documents must be certified true copies and must be accompanied by a certified translation into English by a recognized translator.

LICENSING PROCESS

Submit your complete application to the board with fees and pertinent documents. The licensing examiner assembles the documents for your file and advises the applicant of the application status.

Upon the completion of the application file when all documents have been received from other organizations, the file is forwarded to the board's administrator who reviews the entire file. At the discretion of the administrator, the courtesy license may be issued.

Applications will be processed in the order in which they are received in the board's office. Please insure that you apply well in advance of your need for the permit or license. Board staff will not expedite one application before another.

LICENSE APPLICATION PROCESSING STAFF

If your last name begins with the letters A through K, you may contact your licensing examiner at 907/465-2756.
If your last name begins with the letters L through Z, you may contact your licensing examiner at 907/465-2541.

PAYMENT OF CHILD SUPPORT

Alaska Statute 25.27.244 requires the Division of Occupational Licensing to deny issuance of the professional and occupational licenses of any person reported by the Alaska Child Support Enforcement Division (CSED) as not in substantial compliance with a child support order.

If this office is notified by the CSED that you are not in substantial compliance with a child support order, you may be issued a nonrenewable, temporary license valid for 150 days. The 150-day temporary license period is your opportunity to work with CSED to obtain a release. If you have questions regarding the status of your child support obligation, you may contact CSED at 1-800-478-3300 or (907) 269-6659 to resolve payment issues.

PERSONAL INTERVIEWS

Applicants for medical licensure in Alaska may be required to have a personal interview either with an individual board member or with the full board. Should an interview be required, you will be notified and an interview scheduled. An interview may be required if, during the processing of your application, a question arises for which the board determines it requires additional information from you.

PROCESSING TIME

In general, average processing time for a courtesy license is six to eight weeks. PLEASE PLAN ACCORDINGLY. Application processing time depends to a large extent on the response time from other organizations. Time required also depends upon our workload and the volume of applications being processed. Because the length of processing time for your application may vary considerably, we urge you to be patient until our processing is complete and the permit is issued

If there are any "Yes" responses or if adverse information is received, it will typically take longer to gather and evaluate additional data. If the application is referred to the Investigations Unit for investigation of a particular issue, processing time is extended by the time required to complete an investigation. Since investigations must be prioritized, it may take longer to complete the file.

SOCIAL SECURITY REQUIREMENT

Alaska Statute 08.01.060(b) requires an applicant for an occupational license to provide a United States social security number. Applicants who are foreign citizens and are unable to obtain a social security number must contact the division office for instructions. Social security numbers are required by federal law to be held confidential; we do not release these numbers to the public.

STALE DOCUMENTS

If during the license application process certain documents become older than six months from the date the document was received in our office, that document is considered to be stale and must be resubmitted. Affected documents include the application, verifications of licensure from other licensing jurisdictions, the DEA clearance report, and the FSMB Board Action Data Bank report.

TELEPHONE QUERIES

We have a very small staff and work hard to process applications as quickly as possible. Unnecessary telephone calls to our offices delay processing. If the licensing examiner must spend time answering numerous telephone queries, application processing time is affected. Because of the huge volume of telephone calls regarding the status of applications and because of privacy issues, **we must restrict our telephone responses to the applicant only**. We will not discuss your application with others. If you are concerned about your application being received in our office, mail it "certified – return receipt requested." You will have a verification of delivery returned to you by the post office.

WEBSITE ADDRESS

The Division of Occupational Licensing maintains a website where you may obtain general information about the board or check to see if your license or permit has been issued: www.dced.state.ak.us/occ/pmed.htm.

"YES" RESPONSES

A "Yes" response in the application does not mean your application will be denied. If you have responded "Yes" to any question in the application, additional time will be required for the gathering and assessment of pertinent information. **You can expedite this process by providing complete explanations attached to your application for any "Yes" responses.**

HOW CAN YOU HELP?

1. First and foremost: apply far enough in advance to allow for application processing.
2. If you are concerned about your application being received in our office, mail it Certified - Return Receipt.
3. If you wish to expedite processing as much as you can, send all your verification request forms out via overnight mail and include a return overnight mail envelope addressed to the licensing examiner for the organization's use. This will help them to respond quickly.
4. Insure the application is complete when you submit it and provide any necessary explanations with the application. Print legibly or type your application.
5. Provide complete explanations for any "Yes" responses; it saves time if we don't have to request such information.
6. Provide a brief description for any malpractice claims describing what the allegation was, the nature of the case, your level of involvement, and the resolution of the case.

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MED

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Office Use Only	
Receipt No.	Amount

APPLICATION FOR PHYSICIAN COURTESY LICENSE

PART I PERSONAL IDENTIFICATION INFORMATION (Type or Print Legibly)

1	Full Legal Name (Last, First, Middle)	Last First Middle		
2	Other Names Used (Incl. Maiden Name)			
3	Legal Name Changes (Provide copy of documents)			
4	Date of Birth	Mo Day Year / /	Place of Birth (City, State/Country):	Sex: ☐ M ☐ F
5	Full Practice Address	Mailing Address (Include street address if using post office box) City State Zip Code		
6	Full Residence Address	Mailing Address (Include street address if using post office box) City State Zip Code		Duration at this address: Yrs: Mos:
7	Telephones	Area Code/Phone Work:	Area Code/Phone Home:	
8	Preferred Address of Record (See Address of Record information.)	☐ Use **Practice** Address	☐ Use **Residence** Address	
9	E-Mail Address (Optional)			
10	Professional Designation	☐ MD ☐ DO	Applying Based on: ☐ Credentials (Licensed in other state) ☐ Examination (Not licensed in other state)	
11	Previous License or Permit In ALASKA?	☐ NO ☐ YES	If YES, when and what type: Year:_____ ☐ Resident ☐ Locum Tenens ☐ Permanent License	

12.

APPLICANT: As required by state law, please provide your Social Security Number in the space below. It is considered CONFIDENTIAL Information and is not for public disclosure.

Applicant's Social Security Number _____

PART II **PURPOSE OF THE COURTESY LICENSE** (See approved uses of courtesy license on page 1 of instructions.)

13. Purpose of Courtesy License (check one):

- ☐ Specialty Clinic where patients do not pay fees
- ☐ Specialty Clinic under contract to a state agency
- ☐ Emergency Response as part of organized response to disaster emergency
- ☐ Sports Team Physician
- ☐ Supervised Hospital Fellowship
- ☐ Accompanying Employer-Patient

14. Sponsor/Supervising Physician_____ AK Lic. No._____
(For Fellowship, Supervising Physician)

Facility or
Organization Affiliation_____
(Hospital or facility name, state agency, sports team name,) Location

15. Duration of Event, Clinic, Trip, or Fellowship. License to be valid only for the duration of the activity not to exceed one year.

From: _____ To: _____

PART III **EDUCATION**

16. **Medical School Education**

Name of Institution	Location	Date Graduated

17. **Postgraduate Training** (List Internship, Residency, or Fellowship Training Programs Chronologically)

Name of Institution	Address	Dates From/To	Completed Yes/No
1st Yr			
2nd Yr			
3rd Yr			
4th Yr			
5th Yr			
6th Yr			

18. **Examination History** Please specify National Boards, FLEX, LMCC, USMLE, or a state written examination.

Exam Series	Location	Date Taken	Result (Pass/Fail)

Applicant Name:	**Date of Birth:**

19. **ECFMG Certification - International Graduates Only**

If you are an international medical graduate, have you taken the ECFMG exam? ☐ Yes ☐ No

If Yes, ECFMG Certificate No. _____.
Attach a certified true copy of the certificate to this application.

20. **Specialty** Board certification in an American Board of Medical Specialties member board is required.

ABMS Specialty Board	Date of Certification/ Recertification

PART IV PROFESSIONAL ACTIVITIES

21. **Military Service**

Have you ever been in the armed forces? ☐ Yes ☐ No	If YES, branch of service:
Date of Commission:	Date and Type of Discharge:
Locations where you served:	

22. **Professional Licensure** Please list all states, territories, provinces, or foreign countries in which you hold or have ***ever*** held medical licenses as any health care professional. Include instructional or training permits. You will only be required to verify your state of residence license.

	Location (State, territory, etc.)	License Number	Date Issued	Current Status
1				
2				
3				
4				
5				
6				
7				
8				
9				
10				

If necessary, continue to list on a separate sheet of paper labeled with your name and signed by you.

23. **Medical Societies and Professional Organizations**

Name of Organization	Address	Dates From/To

Applicant Name:	**Date of Birth:**

24. **Hospital Affiliations** Please list all hospitals in which you are currently credentialed.

Name of Institution	Address	When Credentialed?

If necessary, continue to list of a separate sheet of paper labeled with your name and signed by you.

PART V PROFESSIONAL ACTIVITIES (Continued)

25. **Medical Work History**

Please provide a chronological listing of all medical and non-medical activities beginning with your graduation from medical school to the present date with no more than a 60-day gap in time. You may attach a curriculum vitae as long as all information is included. Please explain any gap in time from practice of more than sixty (60) days' duration.

Date From/To	Location	Activity

If necessary, continue to list on a separate sheet of paper labeled with your name and signed by you.

Applicant Name:	**Date of Birth:**

26. **Medical Malpractice History**

Have you ever had any claims of malpractice filed against you? ☐ No ☐ Yes

If Yes, please list all claims of malpractice filed against you below. Include all settlements, judgements, awards, and claims for which no money was paid. For each case listed below, provide a brief description on a separate sheet of paper labeled with your name and signed by you. Include the nature of the case, the allegations, and your response to the allegations. Please do not send letters from attorneys or insurance carriers.

Case No.	Date of Case (Mo/Yr)	Jurisdiction (State, etc.)	Nature of Allegation	Amount of Settlement Paid on Your Behalf
1				
2				
3				
4				
5				
6				

SPECIAL INSTRUCTIONS FOR PARTS VI AND VII

In responding to the questions in Parts IV and V below, please check the appropriate box next to each question. A "Yes" response to a question does not automatically result in a denial of license application. **For each "Yes" response to any question, you must provide a separate, signed statement giving full details including dates, locations, type of action, organizations or parties involved, and specific circumstances.** When in doubt about your response, disclose and provide the explanation requested. Please answer parts A and B of each question.

CONFIDENTIALITY

The contents of licensing files are generally considered public records. If you believe that the additional information you are attaching to explain a "yes" answer should be considered confidential, state that in the attachment. A request for confidentiality may or may not be granted.

PART VI DISCIPLINARY HISTORY

IMPORTANT!
PLEASE READ BEFORE ANSWERING THE DISCIPLINARY HISTORY QUESTIONS.

For the purposes of this application, the word "discipline" is used. There are many forms of disciplinary actions that may be imposed by organizations, schools, programs, licensing authorities, and other agencies. Such disciplinary actions may include but not be limited to: Suspension, Surrender, Revocation, Probation, Reprimand, Censure, Restricted License, Limited License, Conditioned License, or Letters of Counseling, Concern, Advice, Warning, Caution, Admonishment, Reprimand, etc. If you are unsure about your response, please contact our office.

27a. ☐ No ☐ Yes Have you ever been convicted of a crime (felony or misdemeanor) in any jurisdiction of the United States, including military, or any international jurisdiction?

27b. ☐ No ☐ Yes Is any such action pending?

Applicant Name: **Date of Birth:**

Part VI Disciplinary History Questions Continued

28a.	☐ No	☐ Yes	Have you ever been charged with a crime (felony or misdemeanor) in any jurisdiction of the United States, including military, or any international jurisdiction that did not result in acquittal or dismissal?
28b.	☐ No	☐ Yes	Is any such action pending?
29a.	☐ No	☐ Yes	Relating to the practice of medicine, has there ever been a finding of, or have you ever been found guilty of, professional misconduct, unprofessional conduct, incompetence, or negligence, by any jurisdiction of the United States, including military, or any international jurisdiction?
29b.	☐ No	☐ Yes	Is any such action pending?
30a.	☐ No	☐ Yes	Relating to the practice of medicine, have you ever had charges filed against you alleging professional misconduct, unprofessional conduct, incompetence, or negligence, in any jurisdiction of the United States, including military, or any international jurisdiction?
30b.	☐ No	☐ Yes	Is any such action pending?
31a.	☐ No	☐ Yes	Has any hospital or other health care facility disciplined, restricted, or terminated your professional training, employment, or privileges (except for late medical records)?
31b.	☐ No	☐ Yes	Is any such action pending?
32a.	☐ No	☐ Yes	Have you ever voluntarily or involuntarily resigned or withdrawn from professional training, from employment, or your privileges from any hospital or other health care facility to avoid the imposition of disciplinary sanction, restriction, or termination?
32b.	☐ No	☐ Yes	Is any such action pending?
33a.	☐ No	☐ Yes	Have you ever been disciplined by a medical school or post-graduate training program?
33b.	☐ No	☐ Yes	Is any such action pending?
34a.	☐ No	☐ Yes	Have you ever had a license to practice medicine disciplined by any authority including a state medical board or a military authority (except for late medical records)?
34b.	☐ No	☐ Yes	Is any such action pending?
35a.	☐ No	☐ Yes	Have you ever been under investigation by any medical licensing jurisdiction or authority?
35b.	☐ No	☐ Yes	Is any such action pending?
36a.	☐ No	☐ Yes	Have you ever had a medical license application denied by any medical licensing jurisdiction or authority?
36b.	☐ No	☐ Yes	Is any such action pending?

Applicant Name: **Date of Birth:**

37a.	☐ No	☐ Yes	Have you ever voluntarily or involuntarily withdrawn an application for a license to practice medicine in any United States jurisdiction or any international jurisdiction?
37b .	☐ No	☐ Yes	Is any such action pending?
38a.	☐ No	☐ Yes	Have you ever voluntarily or involuntarily surrendered or suspended your license to practice medicine in any United States jurisdiction or any international jurisdiction?
38b.	☐ No	☐ Yes	Is any such action pending?
39a.	☐ No	☐ Yes	Have you ever voluntarily or involuntarily agreed to any limitations, restrictions, or conditions to your license to practice medicine?
39b.	☐ No	☐ Yes	Is any such action pending?

PART VII PERSONAL HISTORY

Please refer to Special Instructions on page 6 before answering these questions. For the purposes of the questions in this section, the following words or phrases are defined:

"Ability to Practice Medicine"
Includes, but is not limited to, the cognitive capacity to make appropriate clinical diagnoses and exercise reasonable medical judgments and to learn and keep abreast of medical developments; the ability to communicate those judgments and medical information to patients and other health care providers with or without the use of aids or devices, such as voice amplifiers; and the physical capability to perform medical tasks such as physical examination and surgical procedures, with or without the use of aids of devices, such as corrective lenses or hearing aids.

"Medical Condition"
Includes physiological, mental, or psychological conditions or disorders, such as, but not limited to, orthopedic, visual, speech, and hearing impairments, cerebral palsy, epilepsy, muscular dystrophy, multiple sclerosis, cancer, heart disease, diabetes, mental retardation, emotional or mental illness, specific learning disabilities, HIV disease, tuberculosis, drug addiction, and alcoholism.

"Chemical Substance(s)"
Any natural or synthetic chemical substance, alcohol, drugs, or medications, including those chemical substances taken pursuant to a valid prescription for legitimate medical purpose and in accordance with the direction(s) of the prescribing physician, as well as those used illegally.

"Controlled Substances"
Means any substance as defined in either Alaska Statute 11.71.900 or the Federal Comprehensive Drug Abuse Prevention and Control Act of 1970, 21 U.S.C.A. Section 801 et seq. (Public Law 91-513) and any subsequent amendment(s).

"Currently"
Does not mean on the day of, or even in the weeks or months preceding the completion of this application; rather, "currently" means recently enough so that the event, condition, behavior, impairment, limitation, etc., may have an ongoing impact on the applicant's ability to practice medicine in a competent manner.

"Illegal Drug Use"
Means the use of an illegally obtained controlled substance or dangerous drug; the term "illegal drug use" also means the use of a legally obtained controlled substance or dangerous drug which is not taken in accordance with the directions of the licensed physician who prescribed the controlled substance or dangerous drug.

Applicant Name:	**Date of Birth:**

Part VII **Personal History Questions Continued**

40.	☐ No ☐ Yes	Has your ability to practice medicine in a competent and safe manner ever been impaired or limited by any condition, behavior, impairment, or limitation of a physical, mental, or emotional nature?
41.	☐ No ☐ Yes	Are you currently experiencing any medical condition or disorder that impairs your judgment or that otherwise affects your ability to practice medicine in a safe and competent manner?
42.	☐ No ☐ Yes	Since completing your postgraduate training, have you ever been physically or mentally unable to practice medicine for a period of sixty (60) days or more?
43.	☐ No ☐ Yes	Are you currently the subject of any civil investigation or court process relating to your ability to practice in a safe and competent manner?
44.	☐ No ☐ Yes	Have you ever been diagnosed with, been treated for, or do you currently have voyeurism, pedophilia, exhibitionism, or any other sexual behavior disorder? (Please note that "sexual behavior disorder" does **not** include sexual preference.)
45.	☐ No ☐ Yes	Are you currently engaged in the illegal use of any drug, whether by ingestion, injection, inhalation, or any other method?
46.	☐ No ☐ Yes	Have you used or are you currently using any chemical substance(s), legal or illegal, that in any way impaired or limited, or is currently impairing or limiting, your ability to practice medicine in a safe and competent manner?
47.	☐ No ☐ Yes	Have you ever been voluntarily or involuntarily committed or confined to any facility for mental health care?
48.	☐ No ☐ Yes	Have you ever been diagnosed with, treated for, or do you currently have (check the appropriate condition): ☐ Bipolar Disorder ☐ Depressive Neurosis ☐ Kleptomania ☐ Hypomania ☐ Any Dissociative Disorder ☐ Pyromania ☐ Schizophrenia ☐ Any Psychotic Disorder ☐ Delirium ☐ Major Depression ☐ Any Organic Mental Disorder ☐ Paranoia
49.	☐ No ☐ Yes	Have you ever taken, or are you currently taking, any chemical substance for any of the disorders listed in question 48 above? If you responded 'Yes' to question 49, on a separate sheet of paper signed and dated by you, please list all medications you are taking, the dosage, frequency, and who is prescribing the medications.
50.	☐ No ☐ Yes	Have you ever been adjudicated or declared incompetent or been the subject of an incompetency proceeding?

Applicant Name: **Date of Birth:**

PART VIII SWORN STATEMENT

I hereby certify that I am the person herein named subscribing to this application. I have read the complete application, and I know the full content thereof.

I declare, under penalty of perjury, that all of the information contained herein and evidence or other credentials submitted herewith are true and correct.

I am the lawful holder of the degree of Doctor of Medicine or Doctor of Osteopathy as prescribed by this application, and that the same was procured in the regular course of instruction and examination, and that it, together with all the credentials submitted were procured without fraud or misrepresentation or any mistake of which I am aware and that I am the lawful holder thereof.

I further certify that the photograph that appears below is a true likeness of myself taken within the past 60 days.

I understand that any falsification or misrepresentation of any item or response in this application, or any attachment hereto or falsification or misrepresentation of credentials to support this application, is sufficient grounds for denying, revoking, or otherwise disciplining a license or permit to practice medicine in the state of Alaska

Applicant Signature_____ Date_____

Affix
Passport Type
Photograph
Here

NOTE: Notary Seal Must Overlie A Portion of the Photograph.

SUBSCRIBED AND SWORN TO before me, a Notary Public, in and for the State of _____.

this _____day of _____, _____.

Notary Signature_____

My commission expires:_____

WARNING: Alaska Statute 11.56.210 states that any person who knowingly or intentionally furnishes false or fraudulent information in this application is subject to imprisonment for not more than one year, a fine of not more than $5,000, or both.

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Office Use Only

COURTESY LICENSE
STATEMENT OF PURPOSE

APPLICANT (please type or print legibly) _____
(Last Name, First, Middle) MD/DO/DPM

DURATION OF ACTIVITY: (Not to exceed one year) START DATE _____ END DATE _____

Please check the appropriate purpose below:

1 ☐ Specialty Clinic where patients do not pay fees

Organization Sponsoring Clinic _____

Type of Clinic _____ Location _____

2. ☐ Sports Team Physician

Team _____

3. ☐ Specialty Clinic under contract to a state agency

State Agency Sponsoring Clinic _____

Type of Clinic _____ Location _____

4. ☐ Supervised Hospital Fellowship

Complete form 08-4288d in the application packet and submit with application.

5. ☐ Emergency Response as part of organized response to a disaster or an emergency

Nature of Emergency _____ Location _____

6. ☐ Accompanying Employer-Patient

Employer/Patient _____

Applicant Signature _____ Date_____

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Office Use Only

AUTHORIZATION FOR RELEASE OF RECORDS

TO WHOM IT MAY CONCERN:

I, _____, residing at
(Please print full name)
_____, hereby authorize the Alaska
(Please print full address)
Division of Occupational Licensing and its investigators to examine my medical and dental records, employment and education records including all training which pertains to my medical practice, and any records pertaining to litigation, judgments, suits, and/or settlements, and any law enforcement records pertaining to me and discuss them with persons having possession of them. I also expressly permit and authorize the release of any and all such records pertaining to me to the Alaska Division of Occupational Licensing and its investigators. This release also applies to all records that pertain to credentialing records at facilities at which I have applied for or held privileges to practice medicine.

I authorize the Division to discuss my records with persons or organizations that are considered appropriate by the Division in connection with an official investigation, and to provide copies of my records to those persons or organizations deemed appropriate by the Division.

This release also applies to any documents or records which contain information pertaining to psychiatric, psychological, drug, or alcohol evaluation, counseling, diagnosis or treatment received by me and which were prepared or made in conjunction with, or under the authority or guidance of any local, state, or federal law which relates to psychiatric, drug or alcohol evaluation, diagnosis or treatment, including all information previously identified, collected, or stored under the authority of any state or federal law, including 42 CFR Part 2.

I request that upon presentation of this release, or a Certified True Copy thereof, that you provide copies of those records to the Division and/or its investigators, and/or representatives of the Office of the Attorney General of the State of Alaska.

This authorization expires one (1) year from the date of my signature below.

_____ _____
Signature of Applicant Date

_____ _____
Home Phone Number Work Phone Number

_____ _____
Date of Birth Social Security Number

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Office Use Only

VERIFICATION OF LICENSURE

Instructions to the Applicant: Please complete Part I below and forward a copy of this form to your state of residence. Type or print legibly.

PART I

Full Name (Last, First, Middle)	Maiden or Other Names Used:		Date of Birth (MM/DD/YYYY)
Mailing Address	City	State	Zip
Medical/Osteopathic School Attended	Location		Year of Graduation
Signature of Applicant			Date of Signature

FOLLOWING TO BE COMPLETED BY STATE BOARD OR OTHER LICENSING JURISDICTION ONLY

Instructions to the licensing agency: Please complete Part II below for the physician identified above and return this document directly to the Alaska State Medical Board.

PART II

LICENSING JURISDICTION		**LICENSE NUMBER**	
INITIAL ISSUE DATE		**EXPIRATION DATE**	
BASIS OF LICENSURE (FLEX, USMLE, etc.)		**CURRENT LICENSE STATUS**	

1. Has this applicant ever been the subject of an investigation by a licensing or disciplinary authority in your state or jurisdiction? ☐ No ☐ Yes
2. Is any such investigation pending? ☐ No ☐ Yes
3. Have formal disciplinary proceedings been initiated against this applicant or the applicant's license by a licensing or disciplinary authority in your state or jurisdiction? ☐ No ☐ Yes
4. Is any such action pending? ☐ No ☐ Yes
5. Has this applicant's license ever been suspended, revoked, disciplined, restricted, warned, placed on probation, or in any other manner limited by a licensing or disciplinary authority in your state? ☐ No ☐ Yes
6. To your knowledge, is there any derogatory information regarding this applicant? ☐ No ☐ Yes

_____ _____
Signed by Date

(Board Seal)

_____ _____
Printed Name Title

ALASKA STATE MEDICAL BOARD

Department of Community and Economic Development
Division of Occupational Licensing
(333 Willoughby Avenue - Ninth Floor)
Post Office Box 110806 Juneau AK 99811-0806
A – K: (907) 465-2756 L – Z: (907) 465-2541
E-mail: license@dced.state.ak.us

Office Use Only

COURTESY LICENSE
FELLOWSHIP SCOPE OF PRACTICE

Instructions to the Applicant: If the purpose of your courtesy license application is to serve in a fellowship, please complete Part I of this form and forward it to the supervising physician.

PART I Applicant Information (Type or print legibly.)

Fellowship Applicant Name _____

Address _____

City/State/Zip _____

Telephone Work_____ Home_____

PART II Supervising Physician Information

Supervising Physician: Please complete Part II below and forward this form directly to the board address above.

Supervising Physician _____ Alaska License No._____

Work Telephone _____ Fax Telephone _____

Fellowship Specialty _____ Dates of Fellowship_____

Affiliated Hospital/ Facility Name and Address _____

_____

Description of the nature of the fellowship and the scope of practice for the fellow physician:

_____

_____

_____

SUPERVISING PHYSICIAN:
The supervising physician shall immediately notify the board, in writing, of the termination of or any change to the supervisory relationship with the courtesy license holder. The supervising physician's responsibility continues until such written notice of termination or change is received by the board.

_____ _____
Signature, Supervising Physician Date Printed Name

NOTARY: SUBSCRIBED AND SWORN TO before me, a notary public in and for the State of _____,

this _____ day of _____, _____.

(Notary Seal)

_____
Signature, Notary Public
My commission expires _____.

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PHYSICIAN
BOARD ACTION DATA BANK INQUIRY

Instructions to the Applicant: Complete Part I below and mail this form directly to the Federation of State Medical Boards at the address below. Type or print legibly.

PART I

Full Name (Last, First, Middle)	Maiden or Other Names Used:	Date of Birth (MM/DD/YYYY)
Mailing Address (Street)		Place of Birth
City/State/Zip		If International Grad., ECFMG No.
Medical/Osteopathic School (Name and Location)		Year of Graduation

APPLICANT: MAIL THIS FORM TO

Federation of State Medical Boards of the United States, Inc.
Post Office Box 619850
Dallas TX 75261-9850

FOLLOWING TO BE COMPLETED BY FSMB DATA BANK STAFF ONLY

PART II

Instructions to the Data Bank Staff: Please search the data bank for any record of this practitioner. Please forward your report to the medical board at the letterhead address.

FOR FEDERATION USE ONLY

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VERIFICATION OF STATUS OF DEA REGISTRATION

Instructions to the Applicant: Type or print legibly. Complete Part I below and mail this form to the DEA.

PART I

Full Name (Last, First, Middle)	Maiden or Other Names Used:		Date of Birth (MM/DD/YYYY)
Mailing Address	City	State	Zip
Address Where DEA Registered			DEA Registration No.
Signature of Applicant			Date of Signature

APPLICANT: MAIL THIS REQUEST FORM TO

Drug Enforcement Administration
Attn: Diversion Unit
400 Second Avenue West
Seattle, WA 98119-4013

FOLLOWING TO BE COMPLETED BY DEA STAFF ONLY

PART II

Instructions to the DEA staff: Please search your records and advise if there is any derogatory information on file against this physician. Please return this form directly to the State Medical Board at the letterhead address.

Comments: _____

_____

_____

_____

_____

For DEA Use Only